of large size and extremely vascular. Cornil thinks that vascularity is the main difference between the vegetation of this and of the simple form of salpingitis which often follows confinement.—*Le Bull. Med.*, May 29.

VII. Laparo-Elytrotomy. GANZINETTI. The main part of this paper is acknowledged to be taken from a pamphlet by Dr. Clark, of Brooklyn.

Contractions of the pelvis necessitate two distinct kinds of operation:

1. Those which involve the death of the fœtus, such as craniotomy, cephalotripsy and embryotomy and their modifications.

2. Those which respect the life of the fœtus, *i. e.*, Porro's operation, one of necessity; and Sänger's or modern Cæsarean section and laparo-elytrotomy, both operations of choice.

Ganzinetti believes that soon the first group of operations will be rejected when the infants are living and for dead ones when the pelvis has more than a medium contraction 65 mm. ($2^1/_2$ inches), because in extreme contraction laparotomy seems to involve less danger to the mother than craniotomy, etc. Formerly, when the mortality of Cæsarean section was from 36% to 60% it was held that this operation should not be performed without the mother's consent, offering her the choice between a greater risk to herself and the certain death of her child. Now, however, that the mortality of Cæsarean section has been reduced to 10%, or about the same as craniotomy, the question is one of choice between the two different methods of laparotomy, Sänger's or laparo-elytrotomy. [For details of the former we are referred to *Annals of Gynecology*, March to June, 1886]. The latter operation is preferred for reasons stated later.

The object of this operation is to reach and open the upper parts of the vagina above the brim of the pelvis, by dividing the abdominal wall down to the peritoneum, and turning this aside until the vaginal wall is reached.

Although out of 14 recorded cases there are 9 deaths, 4 of these must be put down to mistakes in operating, and in the 5 others the patient was so feeble at the operation, after previous efforts at craniot-

omy, as to give any operation small chance of success. In the five successful cases the woman was in a good state at the time of the operation.

The conditions are a living and viable child, the mother's consent, isolated room, temperature 64°–67° F., and antiseptic precautions.

Four assistants are required, one for anæsthetics, one for instruments, one to help the operator, and a nurse to take charge of the infant.

Instruments: Bistouries, grooved directors, dissecting and pressure forceps, retractors, etc.

Bladder and rectum emptied, vagina washed out with 1–2,000 corrosive sublimate lotion, skin of groin and pubes shaved and washed.

1. Incise for 15 to 17 cm. (6 to 6¾ in.) parallel to Poupart's ligament and 1–2 cm. (¾ in.) above it, on either right or left side; divide abdominal wall layer by layer down to the fascia transversalis.

2. Raise peritoneum with the fingers from iliac fossa. This, owing to the effect of the enlarged uterus and to dilatation of the cervix, is easy.

3. Having by a sound in the vagina found where it and the cervix join, open as nearly as possible at that junction and not more than 2 cm. (¾ in.) below it, *i. e*, above the ureter and uterine artery. Vaginal incision is enlarged transversely (Skene), longitudinally (Gaillard, Thomas), obliquely (Garrigues), or crucially (Poullet).

4. By vaginal wound introduce hand into the neck of the uterus and search for the feet to extract by turning, or if the head is already in the vagina to apply the forceps through the abdominal wound and extract.

5. Treat wound in ordinary way, drainage and antiseptics, but do not expect healing by first intention.

The advantages claimed for the operation are that neither the peritoneum nor the uterus are incised, that risk of pelvic cellulitis is no greater than in supra-pubic lithotomy, that fear of hæmorrhage is groundless when operator is methodical. Wound of the ureter is certainly avoided by incising the vagina above its level, and for a similar reason the uterine artery is still more secure.

On several occasions slight cuts in the bladder have formed temporary vesico-vaginal fistulæ. These, with one exception, have rapidly and spontaneously healed. In that one case a subsequent operation was performed for the fistula. All who have tried the operation on the dead and on the living testify that it is more rapid and requires fewer minutiæ than Sänger's.—*Le Bull. Med.*, June 1, 1887.

C. W. CATHCART (Edinburgh).

VIII. A Succcessful Case of Cæsarean Section. By WILLIAM T. LUSK, M.D., (New York). The subject was a primipara, æt. 24, suffering from lameness due to hip disease, which dated back to her eleventh year, at which time sinuses had formed in the neighborhood of the right acetabulum; these were cured, but during the latter part of pregnancy, new suppurating sinuses had appeared. The pelvic measurements were as follows:

	CTM.
Distance between the anterior spines	21.5
Distance between the cristæ ilii	24.
External conjugate	16.
Distance between anterior and posterior spines (right side)	14.5
Distance between anterior and posterior spines (left side)	16.
Diagonal conjugate	9.
Internal conjugate (estimated)	7.5
Distance between the ischia	6.5

While craniotomy was not absolutely impossible, the risk of extracting the child through the natural passages, owing to the combined transverse and antero-posterior narrowing, were considered to equal if not exceed Saenger's modified Cæsarean section; accordingly this operation was performed through an incision extending from a point 3 inches above the umbilicus to within 2 inches of the symphysis pubis. The uterus was then tilted with its left border to the front, and everted from the abdominal opening by firm downward pressure upon the abdominal walls. After the uterus had been turned out the intestines were retained by a large flat sponge placed behind the womb and beneath the abdominal walls. A piece of rubber tubing was placed around the lower segment to control hæmorrhage and the exposed uterus was wrapped in towels wrung out in a warm sublimate solution (1-5000) which were replaced at short intervals.